Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: December 9, 2024

Inspection Number: 2024-1413-0004

Inspection Type:
Critical Incident

Licensee: University Health Network

Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30-31, 2024 and November 1, 4-5, 7-8, 12-15, 18-21, 2024
The inspection occurred offsite on the following date(s): November 6, 2024

The following Critical Incident (CI) intake(s) were inspected:
-Intake: #00119847 [2929-000055-24]; #00122636 [CI #2929-000058-24]- Related to fall incidents
-Intake: #00120987 [CI# 2929-000057-24]; Intake: #00130133 [CI# 2929-000069-24]; Intake: #00127620 [CI# 2929-000066-24]; Intake: #00124585 [CI# 2929-000060-24] - Related to improper care/neglect/abuse
-Intake: #00125506 [CI# 2929-000063-24] - Injury of unknown cause
-Intake: #00129078 [CI# 2929-000067-24] - Related to outbreak management

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
1)A resident's clinical records indicated they had multiple treatments for a specific condition, however the directions for these treatments conflicted with each other.

The Medical Doctor (MD) and Director of Care (DOC) both acknowledged that the directions for administering the treatments were not clearly specified.

Failing to ensure the treatments gave clear directions lead to inconsistent approaches to treating the resident.

Sources: Resident's clinical records; interviews with the MD and DOC.

2)A resident's clinical records indicated they had duplicate treatments for a specific

condition, which caused conflicting directions for the nurses.

The MD and DOC both acknowledged that the above treatments were duplicates and provided conflicting directions to staff.

Failing to ensure the treatment directions were clearly written increased the risk of adverse incidents and harm to the resident.

Sources: Resident's clinical records; interviews with the MD and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident.

Rationale and Summary
1) A resident had a specific condition that predisposed them to negative health outcomes. A Registered Practical Nurse (RPN) identified that the resident had a new health condition but did not notify the MD about it or complete subsequent assessments.

Failure to collaborate with the MD about the new health condition increased the risk of further negative health outcomes for the resident.

Sources: Resident's clinical records, home's investigation notes; interviews with the RPN.

2)A medical specialist completed a consultation note with new recommendations regarding management of a resident's health condition. The RPNs who received the new recommendations did not follow up to ensure the MD reviewed them.

The MD confirmed that they did not see the new recommendations from the specialist and that they did not reassess the resident's treatment plan as a result. The DOC confirmed that the unit nurses should have ensured that the MD reviewed the new recommendations.

The resident experienced worsened symptoms following this incident.

Failing to ensure that the MD reviewed the specialist's recommendations put the resident at risk of worsened health outcomes.

Sources: Resident's clinical records, specialist consultation note; interview with the RPNs, MD, and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of

care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when a resident's care needs changed.

Rationale and Summary
1)A resident's clinical records showed that they experienced a change in their condition, however their care plan was not reassessed and revised.

The Falls Program lead Registered Nurse (RN) acknowledged the care plan should have been revised to reassess the resident's needs given the change in their condition.

There was an increased risk of harm to the resident when their care plan was not reassessed and revised when their care needs changed.

Sources: Resident's clinical records; interviews with the RN.

2)A resident's clinical records showed they were receiving a specific intervention. However, the resident experienced a change in their health condition that conflicted with this intervention.

The Falls Program lead and DOC both acknowledged the care plan should have been revised to reassess the aforementioned intervention.

There was increased risk of harm when the resident's care plan was not reassessed and revised when their care needs changed.

Sources: Resident's clinical records; interviews with the RPN, RN and the DOC.

3)Following a fall incident, a RPN documented preventative recommendations for a resident. These recommendations were not integrated into the resident's care plan and as a result the interventions were not implemented.

The Falls Program lead and the DOC both acknowledged that the resident's care plan should have been reassessed and revised to include these new interventions.

There was an increased risk of falls and injury when the resident's care plan was not reassessed and revised.

Sources: Resident's clinical records; interviews with RPN, RN and DOC.

WRITTEN NOTIFICATION: Foot Care AND Nail Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure that a resident received basic footcare services and toe nail cutting to ensure comfort and prevent infection.

Rationale and Summary
A resident had a specific condition that required their footcare to be provided by a nurse or qualified foot care provider based on the home's policy.

A review of the resident's clinical records showed they did not receive basic footcare and toe nail cutting.

The DOC acknowledged that there was no documentation of foot care by a qualified foot care provider or nurse.

Failing to provide basic foot care and toe nail cutting for the resident put them at increased risk of infection.

Sources: Resident's clinical record, the home's Nail and Foot Care Policy RC 06-01-04, last reviewed November 2023; Interviews with the Personal Support Worker (PSW), RPNs and DOC.

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the fall prevention and management program was implemented in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a fall prevention and management program to reduce the incidence of falls and the risk of injury, and must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program" dated March 2023, as it directed care staff to immediately report any resident fall incidents to the nurse and ensure that the nurse has assessed the resident prior to being transferred or assisted to ambulate post-fall.

Rationale and Summary
A resident had a fall, however the PSW who was present did not report the incident to the nurse on duty. As a result, there were no post-fall assessments completed and the oncoming shift was unaware of the incident.

The PSW confirmed the resident fell, and that they did not inform the nurse. The DOC acknowledged the resident experienced a fall, and that the PSW should have called the nurse, who would have completed the necessary assessments and interventions as per the home's policy.

There was an increased risk of further injury when staff failed to communicate the fall incident as per the home's policy.

Sources: Resident's clinical records, Falls Prevention and Management Program RC-15-01-01, last reviewed March 2023; interviews with the PSW and DOC.

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program was implemented in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a pain management program to identify pain in residents and manage pain and must be complied with.

Specifically, staff did not comply with the policy "Pain Identification and Management" dated March 2023, which directed nurses to complete a comprehensive pain assessment for a new pain concern, use the assessment to develop the plan of care and make referrals to other health professional when needed, and to communicate complaints of new and/or unresolved pain management concerns at every shift report.

Rationale and Summary
1)A resident complained of pain multiple times, but the nurses did not complete a comprehensive pain assessment. Furthermore, the pain complaint was not communicated in the home's shift report so the oncoming shift was unaware.

The RPNs involved acknowledged that the pain assessments were not completed when the resident reported pain.

There was an increased risk of improper treatment of the resident's pain when the home's policy was not followed.

Sources: Resident's clinical records, Pain Identification and Management RC-19-01-01, last reviewed March 2023; interviews with the PSW and RPNs.

2)A resident reported pain to a RPN. After the RPN provided a specific intervention, the pain did not resolve. There was no documentation of a comprehensive pain assessment, follow up interventions, referrals, or updates to the resident's care plan as per the home's policy.

The RPN acknowledged that they did not complete the pain assessment when the resident experienced pain. The DOC confirmed that a pain assessment should have been completed and the MD should have been called when the resident had unresolved pain after the initial intervention.

There was an increased risk of improper treatment of the resident's pain when the home's policy was not followed.

Sources: Resident's clinical records, Pain Identification and Management RC-19-01-01, last reviewed March 2023; interviews with the RPN and DOC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were implemented to respond to responsive behaviours demonstrated by a resident.

Rationale and Summary
A resident's care plan directed staff to implement a specific approach when the resident exhibited a specific responsive behaviour, however the PSWs caring for the resident did not use the intervention.

The PSWs and DOC acknowledged that when the resident exhibited the responsive behaviour, the PSWs did not implement the strategies in the plan of care.

Failure to implement the care plan intervention, placed the resident at risk of harm and injury.

Sources: The home's investigation notes, resident's care plan; interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Medication Management System

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to implement the written policies and protocols for the medication management system for a resident.

Rationale and Summary
The home's procedure titled 'Operations & After-hours' was not followed, hence a resident experienced a delay in starting a new treatment.

A RPN and the DOC both acknowledged that aforementioned procedure was not followed.

Failure to implement the Operations & After-Hours procedure had a negative impact on the resident's health condition.

Sources: The LTCH's investigative notes, Operations & After-Hours procedure, CI; and interviews with the DOC and RPN.

WRITTEN NOTIFICATION: Additional Training- Direct Care Staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure that pain management training was provided to all staff who provided direct care to residents.

Rationale and Summary
The home's records showed that an agency RPN did not receive training on the home's pain management program.

The DOC acknowledged the agency RPN did not receive training on the home's

pain management program.

Failing to provide the required training upon hire could cause staff to not be aware of requirements related to their roles and responsibilities, placing the residents at risk.

Sources: Training Records; interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of Care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1)Provide education to specific PSWs on the home's expectations pertaining to reviewing and following care plans, including the process to communicate if there are concerns implementing an intervention.
a) Maintain a record of the education and training provided including the content, date, signature of attending staff, and the name of person(s) who provided the education.

2)Perform random audits on specific residents to observe that staff are providing care to them as specified in their care plans, for two weeks following receipt of this order, at a minimum three times per week on all shifts.
a) Maintain a record of the audits completed, including date, shift time, person

completing audit, observations made, and content of on-the-spot education provided and/or other corrective actions taken where required.

3)Develop and implement an action plan to ensure staff are checking and following residents care plans, and communicating concerns when appropriate.
a) Maintain a record of the action plan and identify staff roles and responsibilities, and a timeline for the implementation within the compliance due date.

4)Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to residents as specified in their plans.

Rationale and Summary
1)A resident's care plan directed staff to implement specific interventions for their safety, however the intervention was not utilized causing the resident to experience a negative health outcome.

The DOC acknowledged the PSW should have implemented the intervention as directed in their care plan.

There was an increased risk of injury when staff failed to follow the resident's plan of care.

Sources: Resident's clinical records, the home's investigation notes; interviews with the PSW and DOC.

2) A resident's clinical records showed they required safety interventions to prevent falls, however the intervention was not implemented as directed in their care plan.

A PSW acknowledged the intervention was not implemented as indicated in the resident's care plan.

There was an increased risk of injury when the resident's care plan intervention was not implemented.

Sources: Observations; resident's clinical records, the home's investigation notes; interviews with the PSW and DOC.

3)A resident's care plan directed staff to provide a specific intervention, however this intervention was not implemented.

A PSW acknowledged the intervention was not implemented as indicated in the resident's care plan..

Failing to implement the intervention increased the risk of harm to the resident.

Sources: Observations; resident's clinical records; interview with the PSW.

4)A resident's care plan directed staff to apply a specific device, however this device was not implemented.

A PSW acknowledged the device was not implemented as indicated in the resident's care plan.

Failing to follow the care plan increased the risk of harm to the resident.

Sources: Observations; resident's clinical records; interview with the PSW.

This order must be complied with by January 3, 2025

COMPLIANCE ORDER CO #002 Additional Training- Direct Care Staff

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1)Perform an audit on all agency staff working in the home to identify and provide training to those who have not received training on the required programs, specifically Falls Prevention and Management.

2)Maintain a record of the audits completed, including date, time, person completing audit, findings, and/or other corrective actions taken where required.

3)Maintain a record of the education and training provided in section one above including the content, date, signature of attending staff, and the name of person(s) who provided the education.

4)Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to ensure that falls prevention and management training was

provided to all staff who provide direct care to residents.

Rationale and Summary
1)The home's records showed that an agency RPN did not receive training on the home's fall prevention and management program.

The DOC acknowledged the agency RPN did not receive training on the home's fall prevention and management program.

Failing to provide the required training upon hire could cause staff to not be aware of requirements related to their roles and responsibilities, placing the residents at risk.

Sources: Training Records; interview with the DOC.

2) The home did not provide training on falls prevention and management during the orientation of a newly hired PSW.

The DOC acknowledged the PSW did not receive training on the home's fall prevention and management program.

When the home failed to provide the required training upon hire, it could cause staff to not be aware of requirements related to their roles and responsibilities, placing the residents at risk.

Sources: Training Records; interview with the DOC.

This order must be complied with by January 3, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.